

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER The Waterview Shores LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13th Avenue Two Harbors, MN 55616	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and document review, the facility failed to ensure dietary staff adhered to food safety practices during meal preparation. This had the potential to affect residents, guests, and staff receiving meals served from the kitchen. Findings include: During an observation on 7/21/26 at 9:19 a.m., cook (C)-A opened two packages of raw ground meat on a cutting board and placed the meat in a bowl wearing gloves. C-A removed the gloves which had visible meat juices on them and put on new gloves without washing their hands. C-A then went to the fridge, opening the fridge door with a gloved hand, and removed a carton of liquid eggs. C-A returned to the prep table, removed the cutting board containing meat juices, took it to the dishwasher, rinsed it, loaded it in the dishwasher, removed their gloves, and did not wash their hands. C-A removed spices from a cabinet, put on new gloves without handwashing, and returned to the prep table to add ingredients to the bowl containing ground meat. During an interview on 7/21/26 at 9:25 a.m., C-A confirmed they had not washed their hands when changing gloves while making meatloaf and stated they should wash their hands between glove changes. They stated handwashing was important to keep germs out of food. During an interview on 7/21/26 at 10:56 a.m., culinary director (CD) stated they expect the cooks to wear gloves during food preparation, change gloves frequently between tasks, and wash hands in between glove changes. The CD indicated handwashing was important to reduce the risk of transferring bacteria to the new gloves. During an interview on 7/22/26 at 9:58 a.m., the infection preventionist (IP) stated it was important to wash hands when changing gloves to prevent the spread of infection. The IP expected all staff to perform hand hygiene when changing gloves. Handwashing policy dated 2/2024, instructed all employees to do proper hand washing before putting on gloves and after removing gloves. Food Preparation and Service policy revised 4/2019, instructed food preparation staff to adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to change all tube feeding supplies every 24-hours for 1 of 1 (R4) resident reviewed for tube feeding. Findings include: R4's quarterly Minimum Data Set (MDS) dated [DATE] indicated R4 had moderate cognitive impairment. Diagnoses included right sided stroke and dysphagia. The MDS also indicated R4 received tube feedings. R4's care plan undated, indicated a potential alteration in nutrition related to a stroke and no intake by mouth, which required enteral tube feeding. Interventions included enteral feeding and flushes as ordered. The care plan also indicated the syringe, feeding bag, and graduate needed to be changed every twenty-four (24) hours (hr). R4's provider orders undated, indicated the tube feeding syringe needed to be changed daily. During an observation on 7/20/26 at 12:04 p.m., R4's graduated cylinder, holding the tube feeding syringe, was observed on the bedside table with the date of 7/19/26 written on it. The syringe itself was not dated. During a second observation on 7/21/26 at 9:26 a.m., the graduated cylinder with the date of 7/19/26 was again seen on R4's bedside table with an undated syringe in it. During an interview on 7/21/26 at 12:14 p.m., licensed practical nurse (LPN)-A stated the graduate and the tube feeding syringe was to be changed weekly unless there was obvious dirtiness noted on either of them. If obviously dirty, then the graduate and/or syringe would be changed right away. LPN-A examined the graduate and confirmed the date written was 7/19/26. That is the last time any of the tube feeding had been changed that LPN-A was aware of. After the supplies were changed, everything would be documented in the treatment record. During an interview on 7/22/26 at 10:54a.m., the director of nursing/infection preventionist (DON/IP) stated staff were expected to follow the policy related to the changing all tube feeding supplies. The DON/IP reviewed the policy and stated all supplies would need to be changed every 24hrs. The tube feeding supplies needed to be changed every 24 hours because fluids were put in the graduate and the syringe. As the fluids sat in both, the risk of bacteria growth and risk of infection increased. Facility policy Enteral Tube Feeding via Syringe (Bolus) dated 3/24, indicated the staff needed to ensure the syringe had been labeled with the resident's name and the date and time. If the date and time was greater than 24hrs the staff needed to dispose of the supplies and get new.		